HIV PREVENTION COUNSELOR CERTIFICATION COURSE REGISTRATION

State Form 53760 (9-08)
Indiana State Department of Health

INSTRUCTIONS:

The HIV Prevention Counselor Certification Course is a 4-day skills based training for those persons who will provide HIV prevention counseling, testing, and referral (CTR); i.e., partner elicitation. The following guidelines for the course must be followed as conditions of attendance and potential certification for the course.

1. *Prior to attending the CTR course, applicants must complete the Red Cross HIV course or completion of the ISDH proficiency test.*
2. *Attend all four (4) days in their entirety.*
3. *Actively participate and demonstrate skills learned during the course.*
4. *Each participant's skill level will be assessed. Reports and recommendations for each participant will be forwarded to their supervisor and to the HIV Prevention Program at the ISDH.*
5. *Lodging, mileage, and meals are at the agency's or the participant's expense.*
6. ***For questions, call (317) 233-7752 or (317) 233-7051.***
7. *Return completed form to the HIV Prevention Training Manager:*
   a. *by fax at (317) 233-7663; OR*
   b. *mail to: HIV Prevention Training Manager*
      Indiana State Department of Health
      2 North Meridian Street, Section 6C
      Indianapolis, Indiana 46204
8. *If accepted into the course, you will receive confirmation of enrollment approximately two weeks prior to the course date selected. If not accepted for this course, you will be notified and informed as to the reason.*
9. *By signing this form you are agreeing that you have read the above information and understand the expectations and conditions.*

CTR Course Registration

Applicant's Full Name: _____

Agency/Organization: _____

Address: _____

Work Phone Number: (____)_____ Alternate Phone Number: (____)_____

Fax Number: (____)_____ Work E-mail: _____

Occupation/Position: _____

Supervisor's Name: _____

Supervisor's Phone Number: (____)_____ E-mail: _____

Training Date Requesting: _____ (month/day/year)

Reason for taking the course: _____

Prerequisite Documentation

Date Attended Red Cross HIV Course: _____ (month/day/year)

Location of Red Cross Training: _____

Instructor's Name: _____

Sign and Date

Applicant's Signature: _____ Date: _____ (month/day/year)

Supervisor's Signature: _____ Date: _____ (month/day/year)